

Health Attitudes and Beliefs of the Urban Elderly

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THE HEALTH STATUS OF OLDER AMERICANS has attracted increasing Federal and public concern, particularly in the light of evidence that Medicare and Medicaid alone have accounted for 72 percent of the recent inflation in health care costs (1). Unfortunately, this increase in concern has not been paralleled by a proportionate increase in systematic attempts to explore specific health attitudes and behavior of the elderly—attempts that might lead to improvements in preventive health education and in the delivery of health services to this heterogeneous population. The research reported here represents one such attempt.

In the spring and summer of 1976, a survey and analysis was undertaken of the health knowledge, attitudes, and practices of a sample of noninstitutionalized older Americans living in a large metropolitan area—San Francisco, Calif. In view of the effect that socioeconomic status has been shown to have on health knowledge, attitudes, and practices (2a), middle class respondents and lower middle class respondents were compared in these respects with a smaller subsample of respondents living below the poverty line.

Study Sample

Because random sampling of San Francisco's entire elderly population was not feasible, a sample for the survey was drawn at random from three diverse socioeconomic classes—middle, lower-middle, and low (below the poverty line). The total sample consisted of 755 persons 60–102 years old, of whom 468 (63 percent) were women, a sex ratio roughly equivalent to that of the U.S. population 65 years and over in 1975 (3). The average age in the sample was 72.1 years and did not differ significantly by sex. All

members of the sample lived either independently or with relatives or friends.

Group 1. The respondents in group 1, the largest of the three subsamples surveyed, came from a large middle class district in which some 46,000 elderly people resided. A senior information center serving the district provided access to the residents, from whom a random sample of 600 persons 60 years and over was drawn. Upon being contacted in their homes and invited to participate in the survey, 397 of the 600 agreed to fill out a questionnaire.

Group 2. A second subsample of 236 persons was drawn from residents of lower middle class areas attending senior centers in their neighborhoods. Since access to this subsample was based on attendance at the centers, this group was not drawn at random. Nevertheless, the group afforded a physically mobile, lower-middle-income sample for study.

Group 3. A smaller group of 122 elderly persons living in six low-income hotels in the city's "tenderloin" or high-crime red-light district constituted the third subsample. Living on an average of \$290 a month, the respondents in this subsample were drawn at random from hotels typical of this area, in which some 14,000 to 16,000 elderly persons resided.

Group differences. Although groups 1 and 2 did not differ significantly from one another with respect to sex or age, significant differences in these respects were observed when groups 1 and 2 were compared as an aggregate with group 3. Thus, 34.4 percent (42) of the respondents in group 3 were older than 75, compared with only a fifth of those in the other two groups ($P = < 0.01$). A similar significant difference was observed in the sex composition of the groups: women comprised approximately two-thirds of the respondents in groups 1 and 2, while the number of men and women in group 3 was almost identical.

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Study Methods

The respondents filled out a 30-item questionnaire about their perceptions, health beliefs, attitudes, and practices. Although most of this instrument was comprised of statements with which the respondents were to indicate agreement or disagreement, a smaller number of Likert-type scale items were also included, which, because they permitted several degrees of response, could produce more precise answers.

The questionnaire was designed to provide information on the respondents' general satisfaction with life, their perceptions of their own physical, social, mental, and emotional health as compared with that of others in their age group, their attitudes toward specified disease-prevention or health-promoting behavior, and their beliefs about the normal aging process. The respondents were asked to compare themselves with others in their age group as to (a) physical activity, (b) physical health, (c) mental and emotional health, and (d) other factors (such as financial status) that might relate to their overall sense of well-being. To determine how the respondents perceived the health status of the elderly as a whole, they were asked to estimate the proportion of Americans over 65 years who resided in nursing homes.

Study participants were also asked to indicate their agreement or disagreement with a variety of statements about health and aging, such as:

- Memory loss is a normal part of aging.
- Once people have dentures they no longer need to see a dentist.
- Influenza vaccines are generally very effective in preventing flu.
- Women past the childbearing years no longer need to have yearly Pap smears (pelvic examinations).
- Most all of the vision and hearing problems associated with old age could be corrected or ameliorated with proper treatment.

- Older people have a far greater need for vitamin supplements (vitamin pills) than younger people, even if they have nutritious diets.
- One can normally expect to have some loss of vision and hearing as one grows older.
- Persons over 65 who continue to work cannot qualify for Medicare.

Finally, a few questions (addressing, for example, the regularity of physician visits and whether respondents had received influenza vaccinations within the preceding 3 years) were designed to facilitate examination of the relationship between the respondents' stated beliefs about specific preventive measures and their self-reported health behavior in respect to them.

To obtain the participation of the respondents in groups 1 and 2, senior outreach workers visited the residents in their neighborhoods, acquainting them with the aims of the study, soliciting their participation, and distributing the questionnaires to those agreeing to participate. A trained interviewer distributed the questionnaires to potential respondents in group 3, meeting them in their hotels to explain the research objectives and request their cooperation.

Between 60 and 70 percent of the persons contacted in all three groups completed and returned the questionnaires. This response rate is considerably better than the 40 percent normally achieved in such surveys. No significant differences between respondents and nonrespondents were observed with respect to either age or sex. The ethnic composition of the persons receiving the questionnaires was not known. However, the small number of responses (38) from members of minority groups in proportion to their representation in the population suggests that their rate of return was lower than that for whites.

Data from the questionnaires were analyzed, with controls for age and sex, for the entire sample as a whole, and also, for each of the three subsamples.

Although the negligible number of nonwhites did not make analysis by ethnic group feasible, earlier surveys among the elderly (2a) have suggested the potential influence of this variable.

Results

Entire study group. As table 1 indicates, 477 respondents reported that their physical health was "somewhat better" or "much better" than that of most persons their age. Approximately 60 percent similarly stated that their mental and emotional health was "somewhat better" or "much better" than that of their contemporaries; only 4 percent reported that their mental and emotional health compared unfavorably with that of others in their age group. Seventy-two percent of the respondents disagreed strongly with the statement that "in general, I tend to be less physically active than most people my age." This result again reflects the overall trend among the majority of the respondents to evaluate their personal health status positively as compared with that of their peers.

The sharp discrepancies that the respondents perceived between their own health and well-being and that of others in their own age group may in part reflect the negative image that most older people have of the elderly as a group. Indeed, the belief expressed by more than 417 respondents (60 percent), that between one-fourth and one-half of all Americans aged 65 and over reside in nursing homes or long-term-care facilities, underscores the distorted image of aging held in America by many of the elderly themselves. Such negative stereotypes seemed to be particularly pervasive among the elderly poor in the study: 75 percent of these respondents expressed the belief that at least one-fourth of their age-mates were institutionalized.

Table 1. Elderly San Franciscans' perceptions of their physical, mental, and emotional health compared with that of others in their age group, based on 1976 survey

Status compared with others in age group	Physical health		Mental and emotional health	
	Number of persons	Percent of sample	Number of persons	Percent of sample
Much worse or somewhat worse ...	63	8.3	32	4.2
About the same	210	27.8	261	34.6
Somewhat better	233	30.9	249	33.0
Much better	244	32.3	185	24.5
Total	750	99.3	727	96.3

¹ Percentages do not add to 100.0 because of rounding.

Wide discrepancies were noted between what the respondents said they believed and the preventive health actions that they in fact reported taking. Fully half (374) stated that they saw a physician "only when feeling ill." The great majority expressed a belief in the efficacy of influenza vaccines (79.5 percent), the need for routine Papanicolaou smears (90.7 percent), and the value of other preventive health measures requiring regular physician visits (table 2). Of the 546 persons stating a belief that influenza vaccines were effective, only 396 (72 percent) reported they had actually received such a vaccine within the last 3 years. Indeed, as in other groups in the population, there appears to be a significant gap between health knowledge and health behavior

Table 2. Health beliefs and health-related behavior of elderly San Franciscans as self-reported in 1976 survey

Agreement with statements on questionnaire	Total number respond- ing ¹	Group 1		Group 2		Group 3	
		Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent
See doctor only when ill	737						
Agree		176	44.7	118	52.7	80	66.1
Disagree ...		216	55.1	106	47.3	41	33.9
$X^2=17.3$, $df=2$, $P=<0.001$							
Flu vaccines are effective ..	687						
Agree		292	79.1	168	80.8	86	78.2
Disagree		77	20.9	40	19.2	24	21.8
$X^2=0.35$, $df=2$, $P=not\ significant$							
Women past childbearing don't need PAP smears ..	669						
Agree		21	5.7	16	7.8	25	25.5
Disagree ...		346	94.3	188	92.2	73	74.5
$X^2=13.9$, $df=2$, $P=<0.001$							
Dentures pre- clude dentist visits	720						
Agree		35	9.1	23	10.5	25	21.6
Disagree ...		351	90.9	195	89.4	91	78.4
$X^2=10.6$, $df=2$, $P=<0.01$							
Aged need vitamin pills ..	711						
Agree		229	60.4	136	63.6	91	77.1
Disagree ...		150	39.6	78	36.4	27	22.9
$X^2=45.8$, $df=2$, $P=<0.001$							
Working elderly are disqualified for Medicare ..	673						
Agree		41	11.5	25	11.9	40	37.7
Disagree ...		316	88.5	185	88.1	66	62.3
$X^2=45.8$, $df=2$, $P=<0.001$							

¹ Not all 755 respondents answered all questions.

—a gap that can lead to health problems, some of which might be preventable.

In their perceptions of the normal aging process, the respondents once more evidenced some contradictory response patterns. Thus, the great majority (93 percent) agreed that “one can normally expect to have some loss of vision and hearing as one grows older.” Yet at the same time, 77 percent (557) reported their belief that “most all of the vision and hearing problems associated with old age could be corrected or ameliorated with proper treatment.”

A strong association ($P = < 0.01$) was found to exist between the respondents' perceptions of the potential for correcting age-related health problems and positive evaluations of their personal health as compared with that of their peers. Respondents who described their physical health as “somewhat better” or “much better” than that of their age-mates were also more likely to express an optimistic view of the possibility of ameliorating most age-related vision and hearing difficulties. Contrary to expectation, age was not found to bear a significant relationship to the respondents' perceptions of the potential for correcting age-related health problems.

Close to 60 percent of the respondents (421) expressed agreement with the statement that “memory loss is a normal part of aging.” Interestingly, this item was the only one for which both age and sex variables were significantly associated with response patterns. Thus, the male respondents were significantly more likely than the female respondents to agree with the statement ($P = < 0.05$), and within each sex category the percentage in agreement rose significantly with increasing age (table 3).

Only 14 percent of the respondents expressed the belief that they could improve their health “a great deal” if they had the money; more than half (388) stated that money would improve their health “not at all.” Contrary to expectation, the low-income respondents were no more likely than their wealthier counterparts to express the belief that money could improve their health status.

All three groups of respondents, but especially the elderly poor who comprised group 3, exhibited an exaggerated faith in vitamin pills and, also, confusion over Medicare eligibility requirements (see page 431).

Intergroup comparisons. Approximately two-thirds of the middle-income and lower-middle-income respondents in groups 1 and 2 described their physical health as “somewhat better” or “much better” than that of other persons in their age group. Between

one-fourth and one-third in these groups described their health as being “about the same” as that of their contemporaries. Only 9.7 percent of group 1 and only 3 percent of group 2 reported that their health status was “worse” than that of others their age.

In contrast, only 49 percent of the hotel residents in group 3 described their physical health as better than that of their age-mates, and almost 15 percent suggested that they would compare unfavorably on this dimension with others in their age bracket.

The differential reports of the physical health of respondents from groups 1 and 2, on the one hand, and those of the respondents from group 3, on the other, may be explained in part by the significantly greater age of the members of group 3 as compared with the other two groups ($P = < 0.01$). Group 3 thus could be expected to have experienced greater health deterioration. That this difference between the subgroups remains significant, however, when one controls for age ($P = < 0.05$), clearly suggests that other factors are operative. In particular, the difference in the socioeconomic levels of the three groups is believed to play a key role in their reported differential health status, since the poor, regardless of age, have a higher incidence of most chronic and acute disease conditions (6).

The probable role of the socioeconomic variable is further pointed up by national data showing that although poor health is considered a serious problem by only 9 percent of the elderly in the middle-income bracket (annual incomes of \$7,000–\$14,999), 26 percent of those with annual incomes under \$7,000 and 36 percent of those with annual incomes below \$3,000 consider it a serious problem (2a). Indeed, the data from the current study seem to support the National Council on Aging's contention that income plays a greater role than age as a determinant of health problems and related problems among the elderly (2b).

Although the majority of the respondents disagreed with the statement that they were less physically active than most people of their age, the responses of the three groups on this item differed significantly. Thus, although 42 percent of the respondents in group 3 described themselves as less active physically than their age-mates, only 28 percent of group 2 respondents and 24 percent of group 1 respondents so described themselves. The older average age of group 3 respondents again may in part explain their reported lower level of physical activity. Also, however, many group 3 respondents voiced fears of being mugged in explaining their tendency to remain room-bound and hence to lead more sedentary lives.

Table 3. Respondents agreeing and disagreeing with questionnaire statement that "Memory loss is a normal part of aging," by sex and age group

Sex and age group	Respondents agreeing		Respondents disagreeing	
	Number	Percent of sex-age group	Number	Percent of sex-age group
Women				
All ages	247	54.8	204	45.2
60-70	124	47.9	135	52.1
71-80	92	61.3	58	38.7
81 and over ...	31	73.8	11	26.2
$\chi^2=13.7, df=2, P=<0.001$				
Men				
All ages	170	64.8	92	35.1
60-70	74	57.8	54	42.2
71-80	76	70.4	32	29.6
81 and over ...	20	76.9	6	23.1
$\chi^2=5.9, df=2, P=<0.05$				

Again, low socioeconomic status, necessitating residence in a high-crime inner-city area, appears to be linked to a health-related fact of life that on the surface might be attributed simply to age.

Despite the tendency of group 3 respondents to describe their physical health less favorably than members of the other two groups, no such differences were noted with respect to their perceptions of their mental and emotional well-being. Indeed, more than 90 percent of the respondents in each sample group described their own mental and emotional health as "about the same" or "better" than that of others in their age group, and roughly one-fourth of each group suggested that their mental and emotional health was in fact "much better" than that of their peers.

When health behavior was examined by group, again significant differences were noted. As table 1 shows, more than two-thirds of group 3 respondents reported that they saw a doctor "only when feeling ill," as compared with 53 percent of the respondents in group 2 and 45 percent of those in group 1. The trend suggested by these percentages ($P = <0.01$) is again believed partly to reflect socioeconomic differences, since routine physician visits, like other aspects of preventive health behavior, tend to be a practice more typical of higher income groups in our society.

Contrary to expectation, no significant intergroup differences were observed in reported beliefs as to the efficacy of influenza vaccines or in reports of having received a vaccine within the preceding 3 years. In contrast, the groups demonstrated significant divergence in their attitudes toward three other preventive health measures.

First, as table 3 shows, more than one-fourth of the respondents in group 3 held the erroneous belief that women past the childbearing age no longer need routine Papanicolaou smears. In contrast, only 6 percent of the respondents in group 1 and 8 percent of those in group 2 held this notion ($P = <0.001$). The wide discrepancy on this question may reflect in part the different sex ratios of the groups (see Study Sample, page 426). However, the significant difference ($P = <0.05$) that remains, even when sex and age are controlled, suggests again that other factors related to socioeconomic status, such as education, may have an important effect.

Similar diverse intergroup response patterns also were observed on the item about the need for dental checkups by denture-wearers. Close to 22 percent (or 25) of the respondents in group 3 expressed the false belief that dentures negate the necessity of visits to a dentist—a proportion roughly twice as great as that in the other groups.

Group 2's higher proportion of correct answers as compared with group 3 on the item about Papanicolaou smears and on the item about dentures in respect to dentist visits may reflect group 2's greater exposure to health information via neighborhood senior centers and other channels to which their presumed greater mobility gave them access. Such exposure may have partially offset group 2's lower-middle-class economic status, moving its health knowledge and attitudes in the areas studied close to those of group 1 (middle class). In fact, in respect to such items as the perceived proportion of persons over 65 residing in long-term care facilities (table 4), the responses from group 2 reflected considerably more accurate perceptions even than those from group 1.

Table 4. Respondents' perceptions of the proportion of persons in the United States 65 and over residing in nursing homes or long-term care facilities, by study group

Perceived proportion	Group 1 respondents (middle class)		Group 2 respondents (lower middle class)		Group 3 respondents (lower class)	
	Number	Percent	Number	Percent	Number	Percent
Less than 10 percent ..	143	38.9	94	46.8	29	25.4
About 25 percent ..	148	40.2	75	37.3	44	38.6
About 33 percent ..	64	17.4	21	10.4	78	24.6
About 50 percent ..	13	3.5	11	5.5	13	11.4
Total ..	368	100.0	201	100.0	164	100.0

NOTE: $\chi^2=27.8, df=6, P=<0.001$.

As noted, most respondents in each group agreed with the erroneous statement (10) that "older people have a far greater need for vitamin supplements (vitamin pills) than younger people, even if they have nutritious diets." The level of agreement, however, was significantly higher among the low-income hotel dwellers of group 3, of whom 77 percent expressed agreement with the statement. This result may well imply that the elderly poor in group 3, those least able to afford vitamin pills, may be spending significant chunks of an already inadequate food budget on costly diet supplements.

The final and most striking discrepancy observed between the responses of group 3 and the other two groups was in respect to the statement that "persons over 65 who continue to work cannot qualify for Medicare" (table 2). Only about 12 percent of groups 1 and 2 held the erroneous belief that working automatically disqualifies the elderly for Medicare benefits, while close to 38 percent of group 3 held this belief ($P = <0.001$). Since perhaps as many as one-third of the elderly who are poor became poor or dropped below the poverty line upon reaching retirement age, the need for correcting this misinformation is apparent.

The poor in this study were twice as likely as their middle-income counterparts to express a desire for full-time work, and among the elderly nationwide, an estimated 21 percent express a desire for paid employment (2c). Although mandatory retirement and inadequate job opportunities clearly constitute the most critical barriers to fulfilling these desires, the fears expressed by the elderly in this study that working might preclude Medicare benefits also deserve attention. Particularly among the elderly poor, who often desire full-time or part-time employment and also would benefit from it, this misconception must be corrected.

Implications and Conclusions

Although geographic and sampling limitations do not permit generalization of the results of this study to the health attitudes and beliefs of the elderly U.S. population at large, several of the results warrant closer examination.

The research strongly underscores the tendency, already observed previously, for older Americans to hold strong negative stereotypes about members of their own age group. The striking disparity between the proportion of persons 65 and over actually residing in long-term facilities—4 to 5 percent (7)—and the proportion—25 to 50 percent—that 60 percent of the

respondents in the study believe to be institutionalized reflects the distorted image of aging in America that is held even by the elderly themselves. The current research also points up the need for education of the elderly, particularly the low-income elderly, to correct misinformation about Medicare eligibility, the merits of vitamin supplements for older people, and so forth.

Age and sex differences probably partially accounted for the differences in health information and attitudes between the lower and relatively higher socioeconomic groups on a small number of items. Age and sex, however, did not appear to be significantly associated with responses when the total sample was examined as an aggregate. Rather, these demographic factors apparently only worked within the low socioeconomic category to exacerbate trends to which this group's low socioeconomic status gave the major impetus.

The elderly poor in group 3 rated themselves as significantly less physically active than their peers, and such ratings increased with age. National data suggest that 25 percent of the persons aged 75 and older are unable to carry on major physical activity as compared with only 10 percent of the persons aged 65–74 (8). Yet, except for the members of group 3, the respondents 75 and over in the current study did not rate their own physical activity lower than that of other elderly persons. The poor health generally of group 3 respondents, combined with their residence in a high-crime area (which discouraged mobility), probably explains the intergroup differences on this item. For the poor living in such circumstances, age may indeed contribute to a pre-existing health problem.

Large proportions of the respondents noted the value of a variety of preventive health activities requiring regular physician visits; yet half reported that they saw a physician "only when feeling ill." There is a wealth of earlier data indicating the often surprisingly low correlation between what people say they believe and what they in fact do with respect to health practices. In describing his health belief model, Hochbaum (9) suggested that many intervening variables (for example, convenience of a clinic site and a "cue to action") often must be present for a stated health belief to be translated into appropriate health action. This suggestion seems to afford a particularly relevant explanation for the discrepancies between beliefs and practice observed in the current study.

If the health knowledge and attitudes of the elderly are to be aligned more closely with desirable

preventive health behavior, public health interventions may be needed to supply the missing links that Hochbaum mentions. Incentives, such as coupons to be exchanged for a free dental checkup or a small monetary reward (for example, \$5) when a checkup has been obtained, might be offered to encourage a desired health practice. Similarly, improvements in transportation might be introduced to make health care more accessible to the elderly.

Finally, there is a need for further research on a national scale to provide the sound information about the health beliefs, attitudes, and practices of the elderly—and of the elderly poor in particular—that will help to elucidate the needs and interests of this diverse group. Such research could also lay the groundwork for more effective health education programs for the elderly and for policies that would better address this group's concerns about health and related matters.

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SYNOPSIS

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Selected health beliefs, attitudes, and practices of 755 elderly residents of a large metropolitan area were surveyed in 1976. Middle-class, lower-middle-class, and low socioeconomic groups were represented.

A 30-item questionnaire was administered to elicit information on the respondents' general life satisfaction; perceptions of their own physical, mental, and emotional health as compared with that of others in their age group; attitudes toward specific disease prevention or health promotion activities; and beliefs about normal aging processes. The results revealed a strong tendency for the respondents to evaluate their own personal health

and well-being positively as compared with that of others in their age group. However, the grossly exaggerated proportions of elderly Americans whom the respondents believed to be in nursing homes exemplifies the common tendency of the elderly toward strongly negative stereotyping of their own age group. Significant discrepancies were also noted between the respondents' health beliefs (for example, as to the efficacy of influenza vaccines) and their self-reported actions related to health.

Age and sex did not significantly influence responses on the majority of the health-related questions in the survey, but striking differences were observed on some questions when subsamples corresponding to middle, lower-middle and low socioeconomic groups within the community were analyzed separately. As anticipated, the low-income group demonstrated significantly less fa-

vorable perceptions of their physical health status than did their counterparts and a far greater tendency to report that they saw a physician "only when feeling ill." The low socioeconomic group also appeared to be misinformed about preventive health behavior to a significantly greater extent than members of the other two subsamples. In particular, the exaggerated faith in vitamin pills shown by this group of the elderly poor, as well as their significantly greater tendency to believe that working automatically disqualifies a person for Medicare, calls for immediate correction.

The study results also point up the need for better health education of the elderly and more public health interventions in their behalf to counter the prevalent stereotypes of the elderly and the misinformation on which many of the elderly's health-related beliefs, particularly those of the elderly poor, are based.